Iowa Department of Human Services

2017 Provider Quality Management Self-Assessment

October 2017

Objectives

- Overview of the Home and Community Based Services (HCBS) Provider Quality Oversight process
- Familiarize providers with updates to the 2017 Self-Assessment
- Identify and address frequently asked questions
- Provide resources for technical support

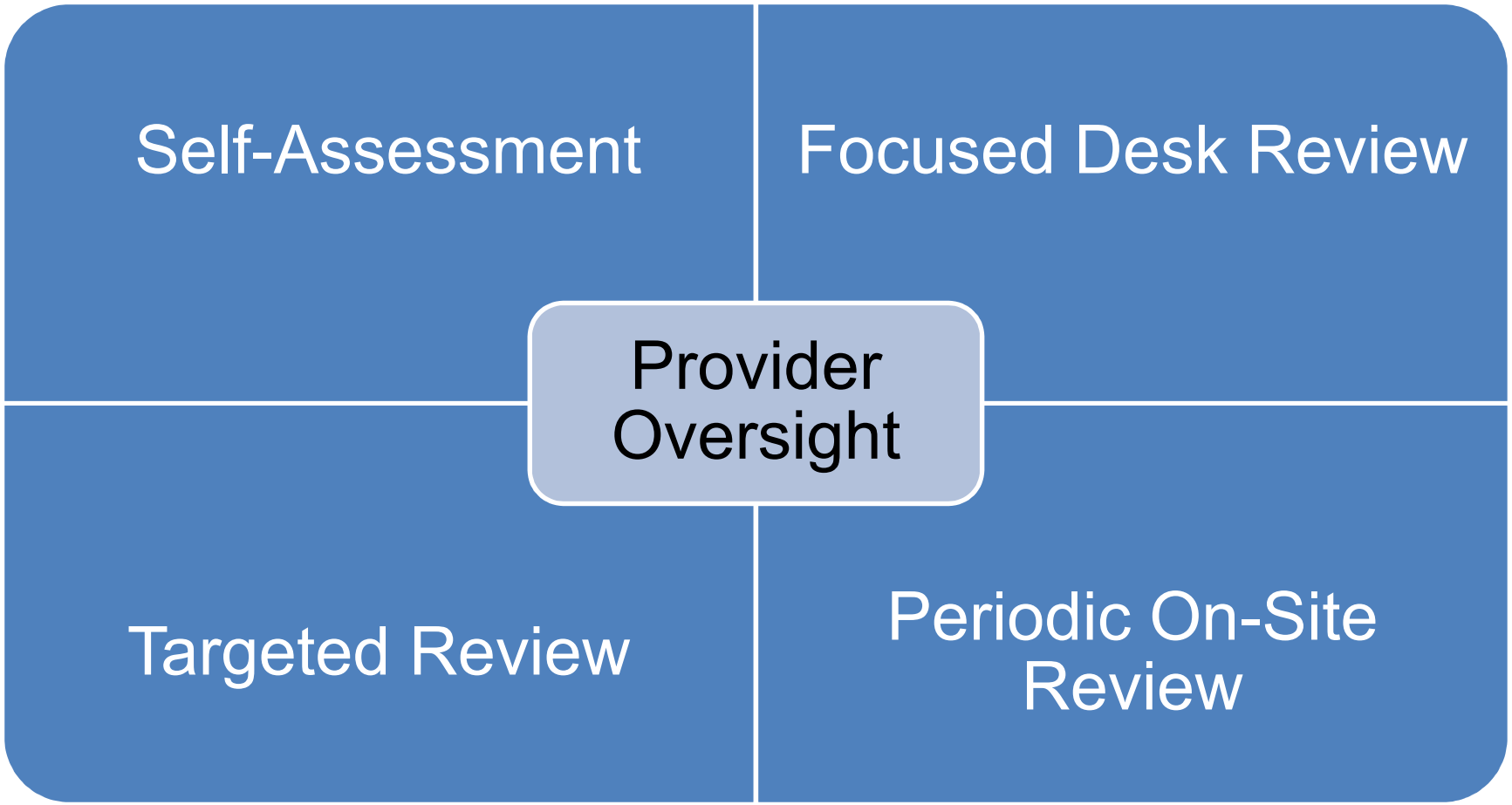
2017 Self-Assessment

- The process is currently underway on the HCBS 2017 Provider Quality Management Self-Assessment Form 470-4547 with submission to occur by December 1, 2017.

- The submission of the self-assessment and participation in IME HCBS quality oversight activities is required for certain provider types to maintain enrollment as an Iowa Medicaid provider.

- A provider who fails to maintain enrollment with Iowa Medicaid will also lose enrollment with any contracted managed care companies.

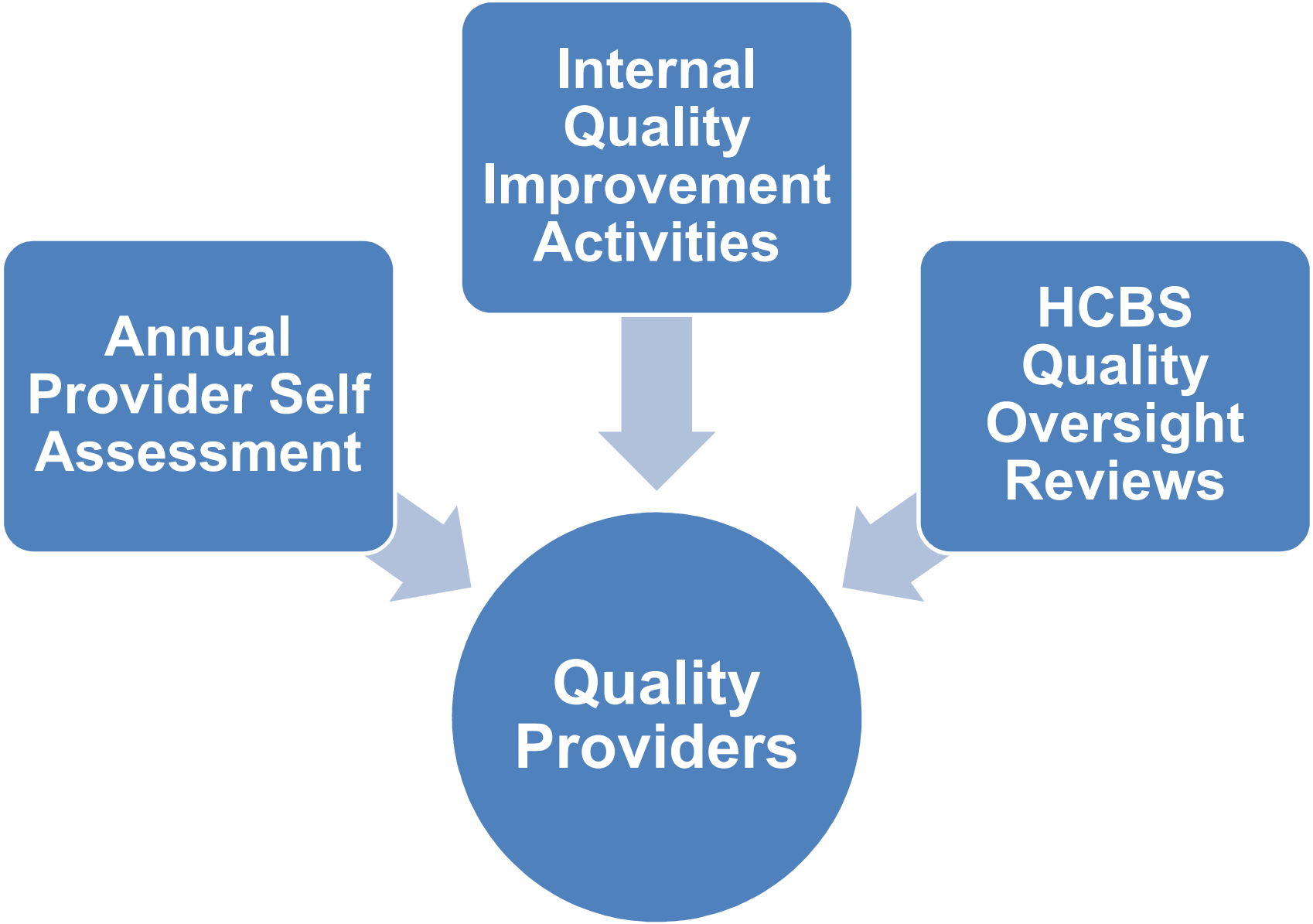
Four Methods of Provider Oversight



	Periodic Review	Focused Review	Targeted Review
What	Full review of required policies, procedures, and evidence	Reviews a select focus area that changes annually	Reviews areas of concern affecting health and safety and service quality
Where	On-site	Desk or on-site review	Desk or on-site review
When	Occur on a five year cycle, or as the provider's certification expires	Yearly sample group of providers	As needed due to concerns

Self-Assessment

- Annual self-reporting tool on standards for identified HCBS waiver providers.
  - Covered services are identified in Section B of the self-assessment
- Standards come from
  - Code of Federal Regulations (CFR)
  - Iowa Code
  - Iowa Administrative Code (IAC)
  - Best practice recommendations
- May require the development of corrective action plans


Internal Quality Improvement Activities
Annual Provider Self Assessment
HCBS Quality Oversight Reviews
Quality Providers

2017 Self-Assessment General Updates

- Form content and submission method remains the same
  - Fillable PDF document, submitted via email
  - Electronic signatures
- Continue to implement the HCBS Settings Statewide Transition Plan through the Address Collection Tool
- Minor changes for efficiency and ease of use

Due Date

- By December 1, 2017
- A completed Address Collection Tool **MUST** accompany your self-assessment submission
- **Incomplete self-assessments will not be accepted.**
  - Revisions need to be resubmitted by the provider by December 1, 2017.
- **Failure to submit the required 2017 Quality Management Self-Assessment by December 1, 2017 will jeopardize your agency's Medicaid enrollment.**

The 2017 Self-Assessment

- http://dhs.iowa.gov/ime/providers/enrollment/provider-quality-management-self-assessment

- Save to your computer by agency name
- Complete electronically
- **Submit through email**
- **Include the completed Address Collection Tool**

Home- and Community-Based Services (HCBS)
2017 Provider Quality Management Self-Assessment

This form is required for entities enrolled to provide services in Section B under the following waivers/programs:

- Health and Disability Waiver (HD)
- AIDS/HIV Waiver
- Elderly Waiver
- Children's Mental Health Waiver (CMH)
- Intellectual Disability Waiver (ID)
- Brain Injury Waiver (BI)
- Physical Disability Waiver (PD)
- HCBS Habilitation Services (Hab)

Each provider is required to submit one, six-section self-assessment by December 1, 2017. This form is to be completed and submitted via fillable PDF as directed on the Provider Quality Management Self-Assessment[1] webpage. A password-protected electronic signature is required in Section E. in order for this document to be accepted. Incomplete self-assessments will not be accepted.

Section A. Identify the agency submitting this form.

Section B. Identify the programs and services your agency is enrolled to provide. If you are uncertain which services you are enrolled for, contact Iowa Medicaid Enterprise (IME) Provider Services at 800-338-7909, option 2 or imeproviderservices@dhs.state.ia.us.

Section C. Select the response option from the "Response Option" column that indicates the most accurate response for each item. If required areas are incomplete, the self-assessment will be returned to the agency and must be resubmitted.

Section D. Please fill out the information as requested

Section E. Please complete and sign as directed

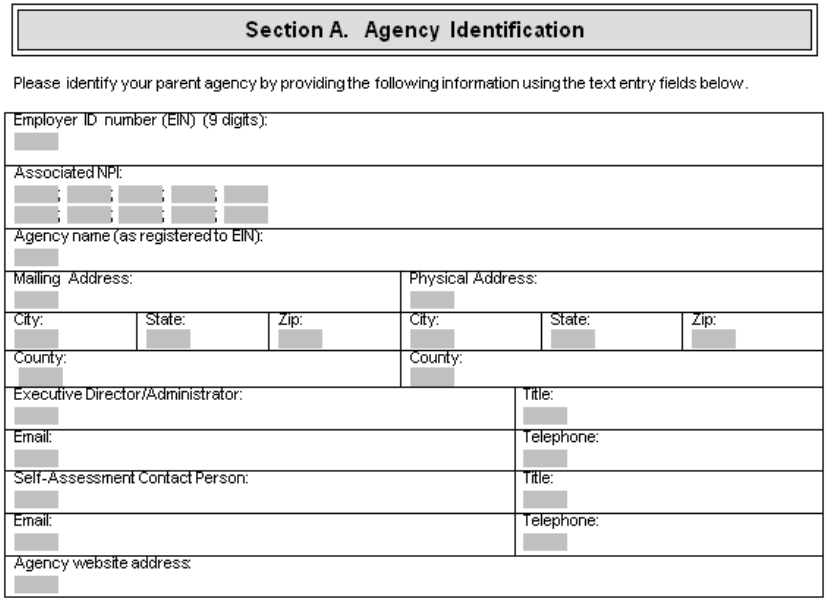
Section F. Please fill out the information as requested.

Questions should be directed to the HCBS Specialist assigned to the county where the parent agency is located. For a complete list of HCBS Quality Oversight Unit contacts and a list of HCBS Specialists by region, please go to the DHS webpage HCBS Waiver Provider Contacts[2]

[1] https://dhs.iowa.gov/ime/providers/enrollment/provider-quality-management-self-assessment
[2] http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/hcbs-contacts

Section A – Agency Identification

- Section A asks for information for the main office. There is a space to list the EIN number (9 digit number) and all applicable agency NPIs (10 digit numbers). List your agency's legal name, if different from name you are doing business as(DBA), as well as correct email addresses.



Section A. Agency Identification

Please identify your parent agency by providing the following information using the text entry fields below.

Employer ID number (EIN) (9 digits):					
Associated NPI:					
Agency name (as registered to EIN):					
Mailing Address:			Physical Address:		
City:	State:	Zip:	City:	State:	Zip:
County:			County:		
Executive Director/Administrator:			Title:		
Email:			Telephone:		
Self-Assessment Contact Person:			Title:		
Email:			Telephone:		
Agency website address:					

Section A – Agency Identification (continued)

- Please clarify if you have agency locations **that operate under a different name**.
- Example: Your main office location operates under the company name but your self-assessment also covers 3 assisted living facilities across the state that operate under different names. Those names, counties, and NPIs should be listed here.

Identify below any affiliated agencies covered under this self-assessment.

Agency name	County	Associated NPI (10 digits)

Section B – Service Enrollment

Section B. Service Enrollment

Indicate *each* of the programs and corresponding services your agency is **enrolled** to provide (regardless of whether or not these services are currently being provided). If your agency is not enrolled for any of the services in this section, you are not required to submit the annual Provider Quality Management Self-Assessment. If you are uncertain as to the services your agency is enrolled for, please contact the IME Provider Services as explained on page one.

Program	AIDS/HIV Waiver	BI Waiver	CMH Waiver
Services	☐ Adult day care ☐ Agency Consumer-Directed Attendant Care (CDAC) ☐ Counseling ☐ Respite	☐ Adult day care ☐ Behavior programming ☐ Agency Consumer-Directed Attendant Care (CDAC) ☐ Family counseling and training ☐ Interim Medical Monitoring and Treatment (IMMT) ☐ Prevocational services ☐ Respite	☐ Family and community support services ☐ In-home family therapy ☐ Respite

Section B – Service Enrollment (continued)

- Select ALL services you are enrolled for.
- You may be enrolled for additional HCBS services not listed in Section B. These services are not part of the self-assessment or HCBS quality oversight process.
- Self-Assessment responses will be based on the policies and procedures the agency utilizes for the services indicated in Section B.

Section C – State and Federal Standards

I. Providers are required to establish and maintain fiscal accountability
IAC Chapters 78 and 79

***At a minimum*, all providers will maintain evidence of:**	**Response Options:**
1. The current rate setting system (*for example*, D-4s, fee schedules, County Rate Information System report)	☐ Yes ☐ No
2. Documentation to support planning and tracking the use of member support dollars that are incorporated into the rate for SCL, RBSCL, home-based habilitation, and family and community support services	☐ Yes ☐ No ☐ N/A
3. The maintenance of fiscal and clinical records for a minimum of five years	☐ Yes ☐ No

If indicating "No," describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):

If indicating "NA," you must describe why the standard(s) are not applicable to your agency:

Section C– State and Federal Standards (continued)

- You must select a response for each standard. Any self-assessments with unanswered standards or comments will be returned and considered not complete.
  - If indicating “Yes”, it means you have a policy and/or evidence in place as required. It is not necessary to explain your response.
  - If indicating “No”, you must describe a corrective action plan (CAP) to meet the standards
  - If indicating “NA”, you must describe why the standard(s) are not applicable to your facility.

Section C - III.
Requirement B. HCBS settings

- 42 CFR 441-310 (c)(4) and 42 CFR 441-710
- Applies to HCBS services covered by the self-assessment.
  - Responses for respite are not required due to the nature of the service
- Respond to standards “a.” through “n.” for each service the agency is enrolled
- **If a service you are enrolled for is not listed under a specific standard, you are not required to provide a response to that standard for that service.**

Requirement B. HCBS settings required for all providers ***At a minimum*, there will be evidence of:**	**Response Options:**
1. Community integration supported by:	
a. The setting is integrated in, and facilitates the member's full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, like members without disabilities	
Adult Day Services	☐ Yes ☐ No ☐ N/A
Agency Consumer-Directed Attendant Care (CDAC)	☐ Yes ☐ No ☐ N/A
Assisted Living Service	☐ Yes ☐ No ☐ N/A
Behavior Programming	☐ Yes ☐ No ☐ N/A
Counseling	☐ Yes ☐ No ☐ N/A
Day Habilitation	☐ Yes ☐ No ☐ N/A
Family Counseling and Training	☐ Yes ☐ No ☐ N/A
Family and Community Support Services	☐ Yes ☐ No ☐ N/A
In-home Family Therapy	☐ Yes ☐ No ☐ N/A
Interim Medical Monitoring and Treatment (IMMT)	☐ Yes ☐ No ☐ N/A
Mental Health Outreach	☐ Yes ☐ No ☐ N/A
Prevocational Services	☐ Yes ☐ No ☐ N/A
Residential-Based Supported Community Living	☐ Yes ☐ No ☐ N/A
Supported Community Living (SCL)	☐ Yes ☐ No ☐ N/A
Supported Employment (SE)	☐ Yes ☐ No ☐ N/A
Habilitation Services	
Day Habilitation	☐ Yes ☐ No ☐ N/A
Home-based Habilitation	☐ Yes ☐ No ☐ N/A
Prevocational Habilitation	☐ Yes ☐ No ☐ N/A
Supported Employment Habilitation	☐ Yes ☐ No ☐ N/A
If indicating "No," describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):	
If indicating "NA," you must describe why the standard(s) are not applicable to your agency:	

Requirement B. HCBS settings (cont.)

- Standards a-f include
  –All HCBS services

- Standards g, h, I, m, n include HCBS services that are
  – Provider-owned, provider-controlled*
  – Residential settings

- Standards i, j, k include HCBS services that are
  – Provider-owned, provider-controlled *
  – Non-residential settings

  * The definition of a provider-owned and controlled setting is included within Section C – III. Requirement B.

Requirement B. HCBS settings (cont.)

Requirement B. "g." through "n." applies to services in provider-owned or controlled settings. As indicated in the approved statewide transition plan (STP), services are provider-owned or provider-controlled if the following conditions are present: If the HCBS provider leases from a third party or owns the property, this would be considered provider-owned or controlled. If the provider does not lease or own the property, but has a direct or indirect financial relationship with the property owner, it would be presumed that the setting was provider-controlled unless the property owner or provider establishes that the nature of the relationship did not affect either the care provided or the financial conditions applicable to tenants. If the member leases directly from the third party that has no direct or indirect financial relationship with the provider, the property is not considered provider-owned or controlled.	**Response Options:**
g. In provider-owned or provider-controlled setting, each member has privacy in their sleeping or living unit	
Agency Consumer-Directed Attendant Care (CDAC)	☐ Yes ☐ No ☐ N/A
Assisted Living Service	☐ Yes ☐ No ☐ N/A
Residential-Based Supported Community Living	☐ Yes ☐ No ☐ N/A
Supported Community Living (SCL)	☐ Yes ☐ No ☐ N/A
Habilitation Services	
Home-based Habilitation	☐ Yes ☐ No ☐ N/A

Requirement B. HCBS settings (cont.)

- A response of "Yes" indicates that the provider can demonstrate evidence of compliance through various agency policies or procedures
  - Evidence may include member service plans, service contracts, lease agreements, member assessments, activity calendars, service documentation
- A written policy on HCBS settings and integration is not currently required, but recommended

Section D – CMS Final Setting Rule New for 2017

Section D. CMS Final Setting Rule

During any HCBS Quality Oversight review process has your agency been required to submit a corrective action plan related to the requirements identified in Section II. Requirement B. HCBS Settings Rule or Section II. Requirement C. Person-Centered Planning 42 CFR 441.301(c)(4) and 42 CFR 441.710(a)? ☐ Yes ☐ No

If "Yes", your agency must submit a status update to your corrective action plan to provide evidence that your agency is on track to meet compliance in this area. Include update below.

Section E – Guarantee of Accuracy

Section E. Guarantee of Accuracy

In submitting this Self-Assessment or signing this Guarantee of Accuracy, the agency and all signatories jointly and severally certify that the information and responses on this Self-Assessment are true, accurate, complete, and verifiable. Further, the agency and all signatories each acknowledge (1) familiarity with the laws and regulations governing the Iowa Medicaid program; (2) the responsibility to request technical assistance from the appropriate regional HCBS Specialist (see contact instructions on page one) in order to achieve compliance with the standards listed within this assessment; (3) the Department, or an authorized representative, may conduct desk or on-site reviews on a periodic basis, as initiated by random sampling or as a result of a complaint. **NOTICE: Any person that submits a false statement, response, or representation, or any false, incomplete, or misleading information, may be subject to criminal, civil, or administrative liability.**

Indicate which accreditation, licensure or certification held, including those which qualify your agency to provide HCBS. Include dates of accreditation/licensure/certification for each selection chosen (MM/YY begin – MM/YY end):

- ☐ Council on Accreditation ____ - ____
- ☐ CARF International ____ - ____
- ☐ Iowa Department of Public Health ____ - ____
- ☐ HCBS Certification ____ - ____
- ☐ The Council on Quality and Leadership (CQL) ____ - ____
- ☐ Department of Inspections and Appeals ____ - ____
- ☐ The Joint Commission (TJC) ____ - ____
- ☐ Chapter 24 ____ - ____
- ☐ Other: ____ - ____

Is your organization in good standing with the accreditation/licensing/certifying organization? ☐ Yes ☐ No

If your organization received less than a three year accreditation/certification, the review results and corrective action plan must accompany the completed *2017 HCBS Provider Quality Management Self-Assessment*.

Is this organization in good standing with the Iowa Secretary of State's Office? ☐ Yes ☐ No

Section E – Guarantee of Accuracy (continued)

- Accreditation/Licensing/Certification needed to provide enrolled HCBS services
  - Include start and end dates as prompted
- Signatures
  - **Should be signed with a secure digital signature.**
  - A help document can be found at: https://helpx.adobe.com/acrobat/11/using/digital-ids.html
  - Work with your HCBS specialist for additional troubleshooting.
  - Self-Assessments without signatures will be returned

Self-Assessment Submission

- Self-Assessment will again be completed electronically
  - Use “Submit” button at the end of the document

    OR
  - Save the completed PDF form and email it as an attachment to hcbsqi@dhs.state.ia.us

- **Do not complete the form by hand, scan, print, fax, or upload through IMPA unless otherwise instructed by your HCBS specialist**

Self-Assessment Submission (continued)

- **Include the REQUIRED Address Collection Tool**

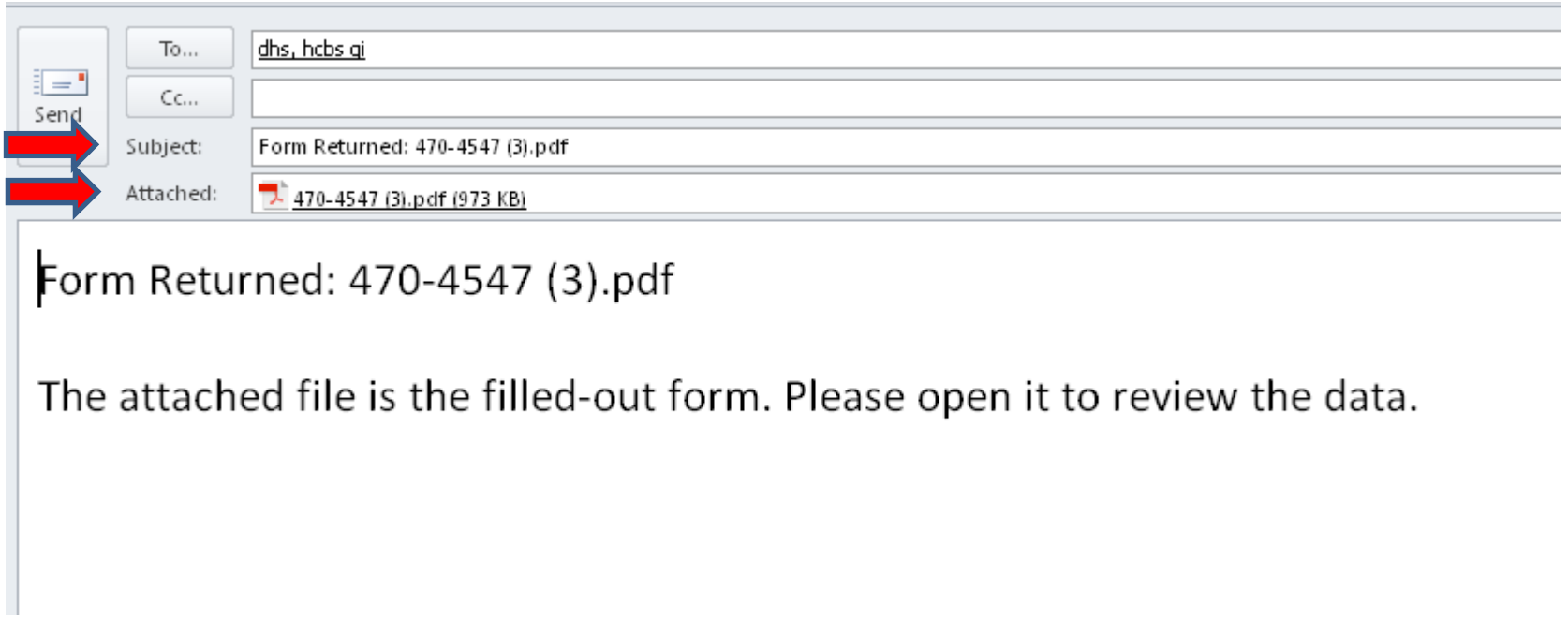
- Other supporting documentation as needed
  - Accreditation Report
  - Corrective Action Plans as needed from Section D

- Attach to the same email as the self-assessment to prevent separation or loss of documents

OR

- Send supporting documents in a separate email with your agency name in the subject line

Self-Assessment Submission (continued)



- **Add attachments as needed**
- **Ensure the email subject line lists your agency name**

Address Collection Tool

- Information on HCBS service setting sites will continue to be collected as indicated in the statewide transition plan to the Centers for Medicare and Medicaid Services (CMS).

- **A 2017 Address Collection Tool has been sent to all providers who submitted a 2016 self assessment**

- **If you are a new provider or did not receive a blank copy of the tool, please request it directly from your HCBS specialist.**

Address Collection Tool

- All providers of services covered by the self assessment **except Respite.**

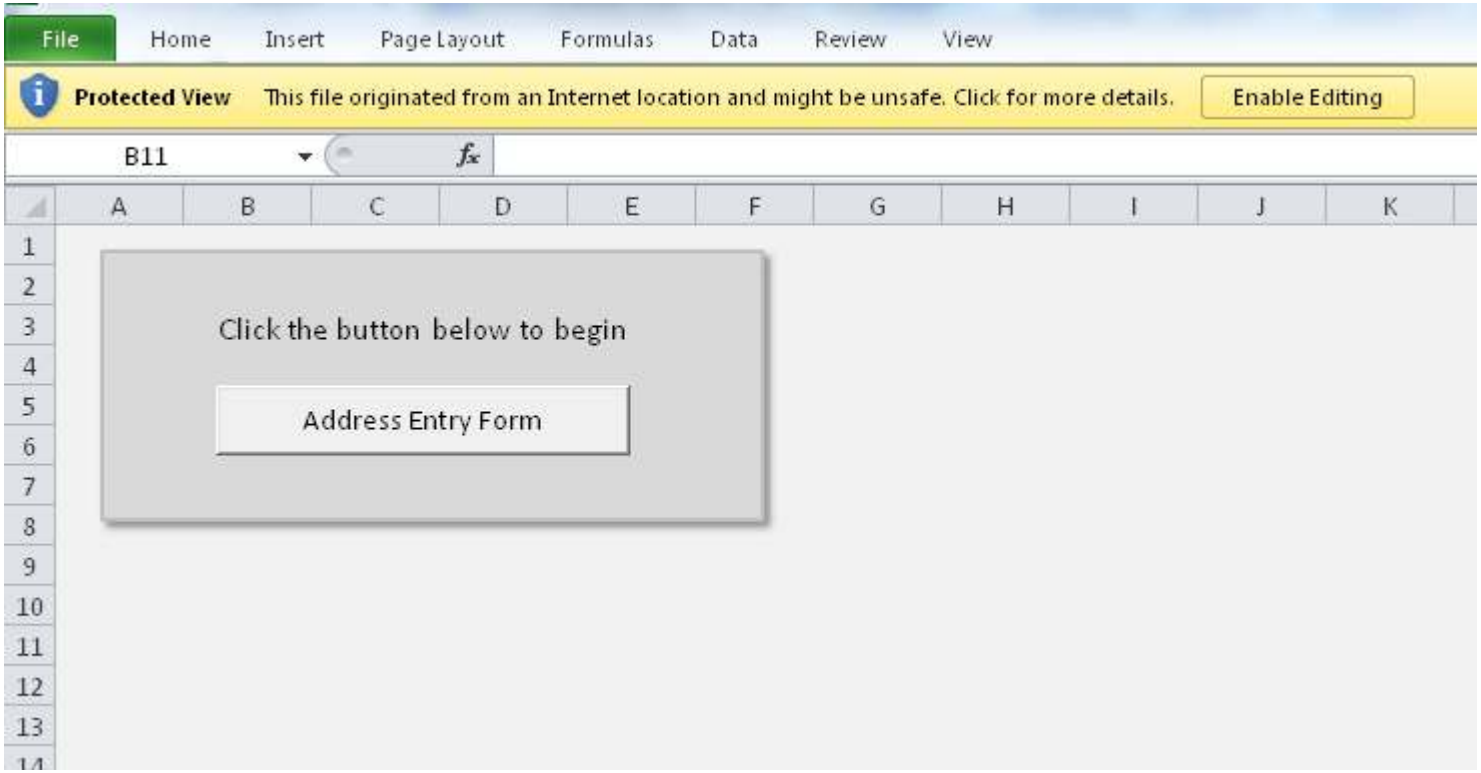
- If you saved your address collection tool from last year, you may be able to copy the information that is still relevant and paste it into the 2017 form in the appropriate tab and columns.
  - Revise and update the data to reflect your agency's current service settings.

Address Collection Tool

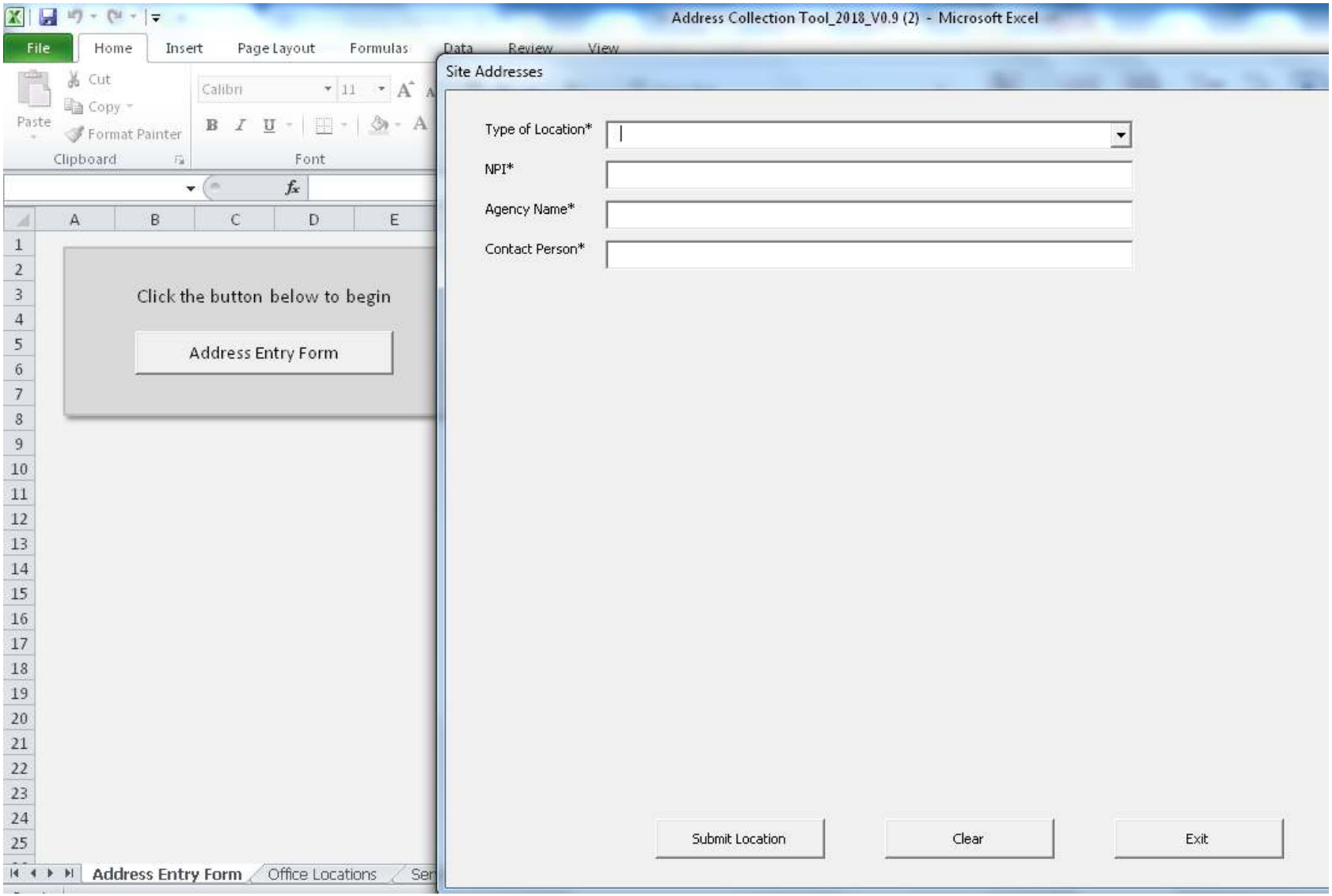
- **Submit all office locations and service provision sites for services identified in Section B, not including respite**
  - Include member addresses if services are provided in the member home's
  - Include office addresses for all agency office locations, regardless of whether services are provided in that location.
  - An office is defined as space is staffed by people who also provide administrative or clerical work and who are not providing direct care services.

Address Collection Tool

- The form is a Microsoft Excel file
  - Select “Enable Editing” and then “Enable Content” in the yellow bar at the top

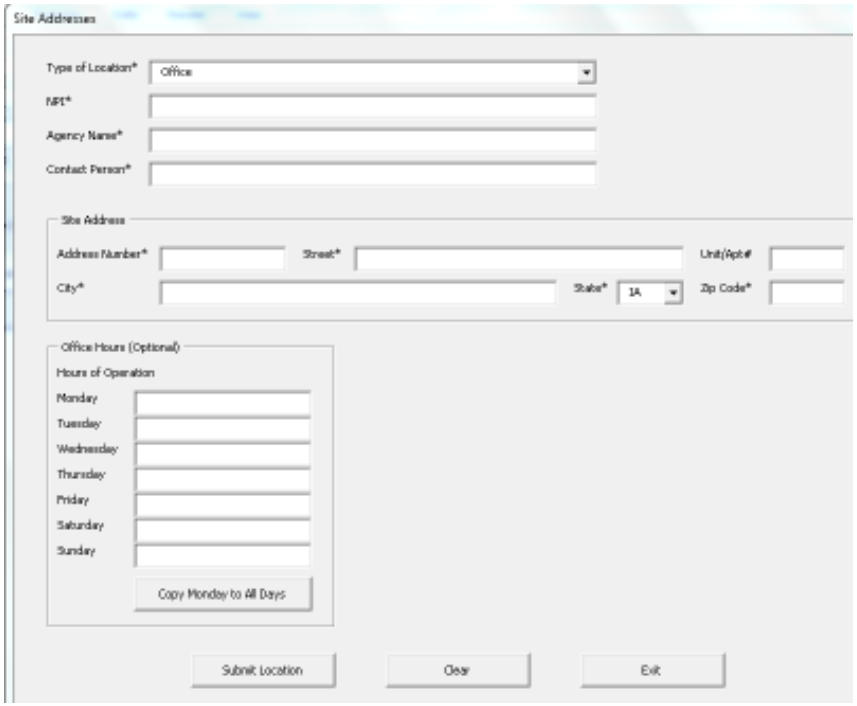


Address Collection Tool

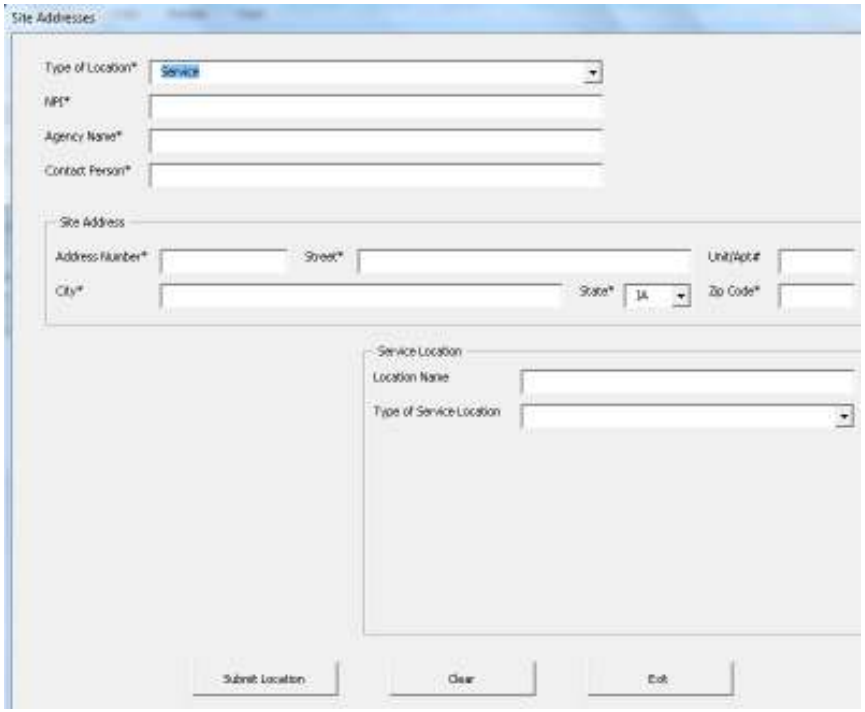


Address Collection Tool

Type of Location: Office



Type of Location: Service



Address Collection Tool
DO Include

- ✓ Agency office locations
- ✓ Member addresses for all waiver funded services covered in Section B of the self-assessment that are provided in the member's home
  - Includes IMMT, counseling and therapy services
- ✓ Group Supportive Employment if provided in a workshop-type setting or an enclave.
- ✓ Community Based or "no walls" Day Habilitation
  - Use primary address

Address Collection Tool
DO NOT Include

- Office locations in member homes that are simply used to store and maintain agency paperwork and supplies.
- Community locations that the member and staff travel to during service delivery
- Community businesses where individual SE is provided
- Respite services
- Elderly Waiver Case Management member addresses
- Elderly Waiver Mental Health Outreach member addresses

Determining Provider-Owned/Controlled

- Provider-owned or controlled:
  - HCBS provider leases from a third party or owns the property
  - Provider does not lease or own the property, but has a direct or indirect financial relationship with the property owner unless the property owner or provider establishes that the nature of the relationship did not affect either the care provided or the financial conditions applicable to tenants.
- Not provider-owned or controlled:
  - Member leases directly from a third party that has no direct or indirect financial relationship with the provider

Submission of Address Collection Tool

- Email the tool to hcbsqi@dhs.state.ia.us along with the completed provider self-assessment
  - Include agency name in the subject line
- Information on service sites and addresses should be submitted via the approved form only
- **Submission of the self-assessment will not be considered complete until the Address Collection Tool is also received**

Timeliness

- Due by December 1, 2017
- Implementation of corrective action to address current CFR, Iowa Code, and IAC standards must be completed within 30 days of the date in Section E.
- **Failure to submit the required 2017 Quality Management Self-Assessment will jeopardize your agency's Medicaid enrollment.**

What to expect following submission

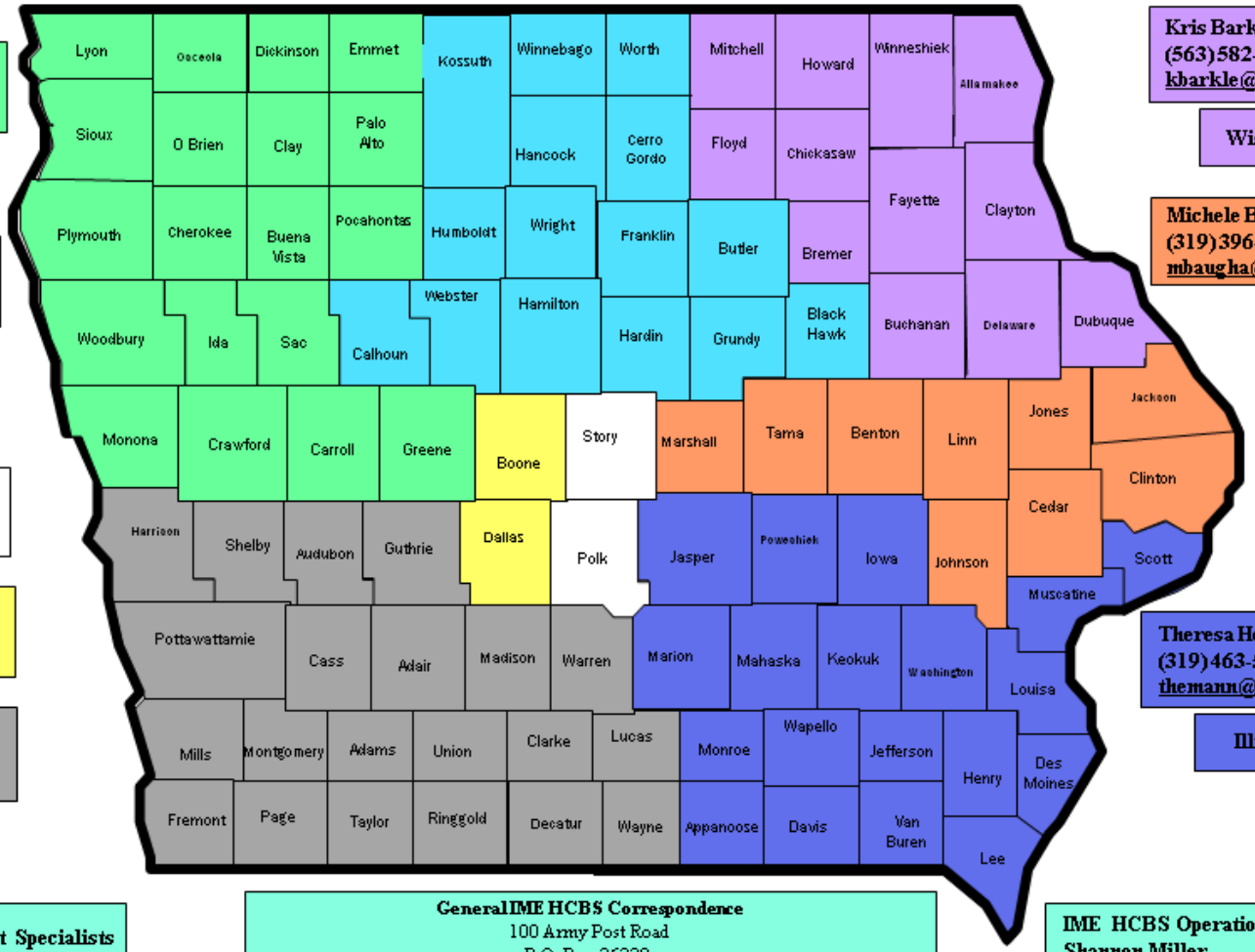
- Providers will receive written letter of acceptance by IME
- Incomplete submission
  - If areas of the self-assessment are incomplete or corrective action was not identified, the provider will be notified and the self-assessment must be resubmitted
  - The December 1, 2017 due date still remains

HCBS Support

- Self-Assessment Website http://dhs.iowa.gov/ime/providers/enrollment/provider-quality-management-self-assessment
  - Frequently Asked Questions (FAQs)
  - Self-Assessment Training Slides
  - Link to regional specialist map
  - Archived Self-Assessment resources

- Archived Informational Letters http://dhs.iowa.gov/ime/providers/rulesandpolicies/bulletins
- Informational Letter sign-up https://secureapp.dhs.state.ia.us/impa

IME HCBS SPECIALIST OVERSIGHT REGIONS



Julene Shelton-Beedle
(712)423-9040
jshelto@dhs.state.ia.us

South Dakota

Rebecca Barber
(319)266-6788
rbarber@dhs.state.ia.us

Minnesota

Courtney Ackerson
(515)974-3038
cackers@dhs.state.ia.us

Emily Roth
(515)334-5516
eroth@dhs.state.ia.us

Paige Shelton
(712)216-1729
pshelto@dhs.state.ia.us

Nebraska

Kris Barkley
(563)582-5658
kbarkle@dhs.state.ia.us

Wisconsin

Michele Baughan
(319)396-3462
mbaugha@dhs.state.ia.us

Theresa Hemann
(319)463-5320
themann@dhs.state.ia.us

Illinois

IME Incident and Complaint Specialists
Lisa Roush
(515)974-3021
lroush@dhs.state.ia.us

General IME HCBS Correspondence
100 Army Post Road
P.O. Box 36330
Des Moines, Iowa 50315
Fax: 515-725-3536
waiverslot@dhs.state.ia.us : Waiverwait list/slot questions
hcbsin@dhs.state.ia.us : Complaints and Incident report follow-up
hcbswaiver@dhs.state.ia.us : General HCBS questions

IME HCBS Operations Manager
Shannon Miller
(515)256-4831
smiller1@dhs.state.ia.us

Revised 9/20/17

Additional Resources

- Centers For Medicare and Medicaid Services http://www.cms.gov/
- Iowa Code and Iowa Administrative Code (IAC): http://search.legis.state.ia.us/nxt/gateway.dll/ic?f=templates&fn=default.htm
- Provider Services: http://dhs.iowa.gov/ime/providers
  - imeproviderservices@dhs.state.ia.us
  - 1-800-338-7909 (toll free) or 515-256-4609 (Des Moines) Select Option 4

Additional Resources

- The HCBS Settings Toolkit
  - released by the Centers for Medicare and Medicaid services (CMS)
  - contains Exploratory Questions designed for Non-Residential HCBS sites.
  - questions are linked on Iowa's HCBS Setting Transition webpage: http://dhs.iowa.gov/ime/about/initiatives/HCBS
  - can be used to evaluate your services to identify the presence or absence of each indicator.
  - **https://dhs.iowa.gov/sites/default/files/exploratory_questions_non_residential.pdf.**

- Send questions to:

hcbsqi@dhs.state.ia.us

Subject: 2017 Self-Assessment